I. STATE/LOCAL USE ONLY

Patient's Name: _____ Phone No.: ( ) _____
(Last, First, M.I.)

Address: _____ City: _____ County: _____ State: _____ Zip Code: _____

RETURN TO STATE/LOCAL HEALTH DEPARTMENT – *Patient identifier information is not transmitted to CDC!* –

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Disease Control and Prevention

PEDIATRIC HIV/AIDS CONFIDENTIAL CASE REPORT
(Patients <13 years of age at time of diagnosis)

CDC Centers for Disease Control and Prevention

DATE FORM COMPLETED: Mo. Day Yr.

REPORT SOURCE:

II. HEALTH DEPARTMENT USE ONLY

Form Approved OMB No. 0920-0573 Exp Date 2/28/2010

SOUNDEX CODE:

REPORT STATUS: [1] New Report [2] Update

REPORTING HEALTH DEPARTMENT: State: _____ City/ County: _____

State Patient No.:

City/County Patient No.:

III. DEMOGRAPHIC INFORMATION

DIAGNOSTIC STATUS AT REPORT: (check one) [3] Perinatally HIV Exposed [4] Confirmed HIV Infection (not AIDS) [5] AIDS [6] Seroreverter

DATE OF LAST MEDICAL EVALUATION: Mo. Yr.

DATE OF BIRTH: Mo. Day Yr.

AGE AT DIAGNOSIS: Years Months
HIV Infection (not AIDS) ...
AIDS .....

CURRENT STATUS: [1] Alive [2] Dead [9] Unk.

DATE OF DEATH: Mo. Day Yr.

STATE/TERRITORY OF DEATH:

DATE OF INITIAL EVALUATION FOR HIV INFECTION: Mo. Yr.

Was reason for initial HIV evaluation due to clinical signs and symptoms? Yes [1] No [0] Unk. [9]

SEX: [1] Male [2] Female

ETHNICITY: (select one) [1] Hispanic [2] Not Hispanic or Latino [9] Unk.

RACE: (select one or more)
[ ] American Indian/ Alaska Native [ ] Native Hawaiian or Other Pacific Islander
[ ] Asian [ ] White
[ ] Black or African American [ ] Unk

COUNTRY OF BIRTH:
[1] U.S. [7] U.S. Dependencies and Possessions (including Puerto Rico) (specify): _____
[8] Other (specify): _____ [9] Unk.

RESIDENCE AT DIAGNOSIS:
City: _____ County: _____ State/ Country: _____ Zip Code: _____

IV. FACILITY OF DIAGNOSIS

Facility Name: _____ City: _____ State/ Country: _____

FACILITY SETTING (check one) [1] Public [2] Private [3] Federal [9] Unk.

FACILITY TYPE (check one) [01] Physician, HMO [31] Hospital, Inpatient [88] Other (specify): _____

V. PATIENT/MATERNAL HISTORY *(Respond to ALL categories)*

• **Child's biologic mother's HIV Infection Status:** (check one)
[1] Refused HIV testing [2] Known to be uninfected after this child's birth [9] HIV status unknown

Diagnosed with HIV Infection/AIDS:
[3] Before this child's pregnancy [5] At time of delivery [7] After the child's birth
[4] During this child's pregnancy [6] Before child's birth, exact period unknown [8] HIV-infected, unknown when diagnosed

• **Date of mother's first positive HIV confirmatory test:** ..... Mo. Yr.

• **Mother was counseled about HIV testing during this pregnancy, labor or delivery?** ..... Yes [1] No [0] Unk. [9]

After 1977, this child's biologic mother had: Yes No Unk.
- Injected nonprescription drugs ..... [1] [0] [9]
- *HETEROSEXUAL* relations with:
  - Intravenous/injection drug user ..... [1] [0] [9]
  - Bisexual male ..... [1] [0] [9]
  - Male with hemophilia/coagulation disorder ..... [1] [0] [9]
  - Transfusion recipient with documented HIV infection ..... [1] [0] [9]
  - Transplant recipient with documented HIV infection ..... [1] [0] [9]
  - Male with AIDS or documented HIV infection, risk not specified .. [1] [0] [9]
- Received transfusion of blood/blood components (other than clotting factor) ..... [1] [0] [9]
- Received transplant of tissue/organs or artificial insemination ..... [1] [0] [9]

Before the diagnosis of HIV Infection/AIDS, this child had: Yes No Unk.
- Received clotting factor for hemophilia/coagulation disorder ..... [1] [0] [9]
  (specify disorder): [1] Factor VIII (Hemophilia A) [2] Factor IX (Hemophilia B) [8] Other (specify): _____
- Received transfusion of blood/blood components (other than clotting factor) ..... [1] [0] [9]
  First: Mo. Yr. Last: Mo. Yr.
- Received transplant of tissue/organs ..... [1] [0] [9]
- Sexual contact with a male ..... [1] [0] [9]
- Sexual contact with a female ..... [1] [0] [9]
- Injected nonprescription drugs ..... [1] [0] [9]
- Other (Alert State/City NIR Coordinator) ..... [1] [0] [9]

VI. STATE/LOCAL USE ONLY

Physician's Name: _____ Phone No.: ( ) _____ Medical Record No. _____
(Last, First, M.I.)

Hospital/Facility: _____ Person Completing Form: _____ Phone No.: ( ) _____

– Physician identifier information is not transmitted to CDC! –

VII. LABORATORY DATA

1. HIV ANTIBODY TESTS AT DIAGNOSIS: (Record all tests, include earliest positive)

	Positive	Negative	Indeterminate	Not Done	TEST DATE Mo.	TEST DATE Yr.
• HIV–1 EIA	1	0	–	9		
• HIV–1 EIA	1	0	–	9		
• HIV–1/HIV–2 combination EIA	1	0	–	9		
• HIV–1/HIV–2 combination EIA	1	0	–	9		
• HIV–1 Western blot/IFA	1	0	8	9		
• HIV–1 Western blot/IFA	1	0	8	9		
• Other HIV antibody test (specify): _____	1	0	8	9		

2. HIV DETECTION TESTS:
(Record all tests, include earliest positive)

	Positive	Negative	Not Done	TEST DATE Mo.	TEST DATE Yr.
• HIV culture	1	0	9		
• HIV culture	1	0	9		
• HIV antigen test	1	0	9		
• HIV antigen test	1	0	9		
• HIV DNA PCR	1	0	9		
• HIV DNA PCR	1	0	9		
• HIV RNA PCR	1	0	9		
• HIV RNA PCR	1	0	9		
• Other, specify _____	1	0	9		

3. HIV VIRAL LOAD TEST: (Record all tests, include earliest detectable)

*Type: 11. NASBA (Organon) 12. RT-PCR (Roche) 13. bDNA(Chiron) 18. Other

Test type*	Detectable Yes	Detectable No	Copies/ml	Test Date Mo.	Test Date Yr.
	1	0			
	1	0			

4. IMMUNOLOGIC LAB TESTS: (At or closest to current diagnostic status)

	Mo.	Yr.
• CD4 Count _____ cells/µL		
• CD4 Count _____ cells/µL		
• CD4 Percent _____ %		
• CD4 Percent _____ %		

5. If HIV tests were not positive or were not done, or the patient is less than 18 months of age, does this patient have an immunodeficiency that would disqualify him/her from the AIDS case definition? ..... Yes 1 No 0 Unk. 9

6. If laboratory tests were not documented, is patient confirmed by a physician as:

	Yes	No	Unk.	Date of Documentation Mo.	Date of Documentation Yr.
• HIV-infected	1	0	9		
• Not HIV-infected	1	0	9		

VIII. CLINICAL STATUS

AIDS INDICATOR DISEASES	Initial Diagnosis Def.	Initial Diagnosis Pres.	Initial Date Mo.	Initial Date Yr.
Bacterial infections, multiple or recurrent (including Salmonella septicemia)	1	NA		
Candidiasis, bronchi, trachea, or lungs	1	NA		
Candidiasis, esophageal	1	2		
Coccidioidomycosis, disseminated or extrapulmonary	1	NA		
Cryptococcosis, extrapulmonary	1	NA		
Cryptosporidiosis, chronic intestinal (>1 mo. duration)	1	NA		
Cytomegalovirus disease (other than in liver, spleen, or nodes) onset at >1 mo. of age	1	NA		
Cytomegalovirus retinitis (with loss of vision)	1	2		
HIV encephalopathy	1	NA		
Herpes simplex: chronic ulcer(s) (>1 mo. duration); or bronchitis, pneumonitis or esophagitis, onset at >1 mo. of age	1	NA		
Histoplasmosis, disseminated or extrapulmonary	1	NA		
Isosporiasis, chronic intestinal (>1 mo. duration)	1	NA		

AIDS INDICATOR DISEASES	Initial Diagnosis Def.	Initial Diagnosis Pres.	Initial Date Mo.	Initial Date Yr.
Kaposi's sarcoma	1	2		
Lymphoid interstitial pneumonia and/or pulmonary lymphoid hyperplasia	1	2		
Lymphoma, Burkitt's (or equivalent term)	1	NA		
Lymphoma, immunoblastic (or equivalent term)	1	NA		
Lymphoma, primary in brain	1	NA		
Mycobacterium avium complex or *M.kansasii*, disseminated or extrapulmonary	1	2		
M. tuberculosis, disseminated or extrapulmonary*	1	2		
Mycobacterium, of other species or unidentified species, disseminated or extrapulmonary	1	2		
Pneumocystis carinii pneumonia	1	2		
Progressive multifocal leukoencephalopathy	1	NA		
Toxoplasmosis of brain, onset at >1 mo. of age	1	2		
Wasting syndrome due to HIV	1	NA		

Def. = definitive diagnosis Pres. = presumptive diagnosis

Has this child been diagnosed with pulmonary tuberculosis?* 1 Yes 0 No 9 Unk. If yes, initial diagnosis and date: 1 Definitive 2 Presumptive Mo. Yr.

*RVCT CASE NO.:

IX. BIRTH HISTORY (for PERINATAL cases only)

Birth history was available for this child: [1] Yes [0] No [9] Unk. *If No or Unknown, proceed to Section X.*

HOSPITAL AT BIRTH:

Hospital:_____ City:_____ State:_____ Country:_____

RESIDENCE AT BIRTH:

City:_____ County:_____ State/ Country:_____ Zip Code:_____

BIRTHWEIGHT: (enter lbs/oz OR grams)

____ lbs. ____ oz

____ grams

BIRTH: Type: .... [1] Single [2] Twin [3] >2 [9] Unk.

Delivery: ..... [1] Vaginal [2] Elective Caesarean [3] Non-elective Caesarean [4] Caesarean, unk. type [9] Unk.

Birth Defects: .... [1] Yes [0] No [9] Unk.

Specify type(s): _____ Code: ____.____

NEONATAL STATUS:

[1] Full term

[2] Premature

Weeks ____ 99 = Unk.

PRENATAL CARE:

Month of pregnancy prenatal care began: ____ mos. 99 = Unk. 00 = None

Total number of prenatal care visits: ____ 99 = Unk. 00 = None

	Refused	Yes	No	Unk.
• Did mother receive zidovudine (ZDV, AZT) during pregnancy?	[8]	[1]	[0]	[9]
• If yes, what week of pregnancy was zidovudine (ZDV, AZT) started? Weeks: ____ 99 = Unk.				
• Did mother receive zidovudine (ZDV, AZT) during labor/delivery?	[8]	[1]	[0]	[9]
• Did mother receive zidovudine (ZDV, AZT) prior to this pregnancy?		[1]	[0]	[9]

	Yes	No	Unk.
• Did mother receive any other Anti-retroviral medication during pregnancy?	[1]	[0]	[9]
If yes, specify: _____			
• Did mother receive any other Anti-retroviral medication during labor/delivery?	[1]	[0]	[9]
If yes, specify: _____			

Maternal Date of Birth Mo. Day Yr. ____

Maternal Soundex: ____ _____

Maternal State Patient No. _____

Birthplace of Biologic Mother:

[1] U.S. [7] U.S. Dependencies and Possessions (including Puerto Rico) (specify): _____

[8] Other (specify): _____ [9] Unk.

X. TREATMENT/SERVICES REFERRALS

This child received or is receiving:

	Yes	No	Unk.	DATE STARTED Mo. Day Yr.
• Neonatal zidovudine (ZDV, AZT) for HIV *prevention*	[1]	[0]	[9]	____ ____ ____
• Other neonatal anti-retroviral medication for HIV *prevention*	[1]	[0]	[9]	____ ____ ____
If yes, specify: _____				
• Anti-retroviral therapy for HIV *treatment*	[1]	[0]	[9]	____ ____ ____
• PCP prophylaxis	[1]	[0]	[9]	____ ____ ____

Was child breastfed? [1] Yes [0] No [9] Unk.

This child has been enrolled at:

Clinical Trial: [1] NIH-sponsored [2] Other [3] None [9] Unk.

Clinic: [1] HRSA-sponsored [2] Other [3] None [9] Unk.

This child's medical treatment is primarily reimbursed by:

[1] Medicaid [4] Other Public Funding

[2] Private insurance/HMO [7] Clinical trial/government program

[3] No coverage [9] Unk.

This child's primary caretaker is:

[1] Biologic parent(s) [2] Other relative [3] Foster/Adoptive parent, relative [4] Foster/Adoptive parent, unrelated [7] Social service agency [8] Other (specify in Section XI.) [9] Unk.

XI. COMMENTS:

(XI. COMMENTS CONTINUED ON THE BACK)

XI. COMMENTS (continued)